



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

METROPLEX SURGICARE
1600 CENTRAL DRIVE SUITE 180
BEDFORD TX 76022

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-4943-01

MFDR Date Received

AUGUST 26, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier did not pay claim according to the Texas A.S.C. fee schedule."

Amount in Dispute: \$2185.93

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual maintains its position no additional payment is due."

Response Submitted by: Texas Mutual Insurance Co., 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 29, 2011	ASC Services for CPT Code 49507-LT	\$1,481.29	\$1,481.23
	ASC Services for CPT Code 49507-RT	\$704.64	\$704.64
TOTAL		\$2,185.93	\$2,185.87

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated June 20, 2011

- CAC-W1-Workers compensation state fee schedule adjustment.
- CAC-59-Processed based on multiple or concurrent procedure rules. (For example multiple surgery or

diagnostic imaging, concurrent anesthesia.)

- 627-The bilateral procedure rules have been applied to this procedure code.
- 790-This charge was reimbursed in accordance to the Texas medical fee guideline.

Explanation of benefits dated July 18, 2011

- CAC-W1-Workers compensation state fee schedule adjustment.
- CAC-W3-Additional payment made on appeal/reconsideration.
- 723-supplemental reimbursement allowed after reconsideration of services.
- CAC-59-Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)
- 627-The bilateral procedure rules have been applied to this procedure code.
- 790-This charge was reimbursed in accordance to the Texas medical fee guideline.

Explanation of benefits dated August 5, 2011

- CAC-W1-Workers compensation state fee schedule adjustment.
- CAC-18-Duplicate claim/service.
- 736-Duplicate appeal. Network contract applied by Texas Star Network.
- CAC-59-Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)
- 627-The bilateral procedure rules have been applied to this procedure code.
- 790-This charge was reimbursed in accordance to the Texas medical fee guideline.

Issues

1. Does a contractual agreement issue exist in this case?
2. Did the requestor support position that additional reimbursement is due for CPT codes 49507-LT and 49507-RT?

Findings

1. According to the explanation of benefits, the respondent raised the issue of a network contract; however, the explanation of benefits does not indicate that a contractual reduction was taken. Furthermore, the respondent did not submit any documentation to support that a contractual agreement exists; therefore, the disputed services will be reviewed per applicable division rules and fee guidelines.
2. 28 Texas Administrative Code §134.402(d) states “ For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section.”

28 Texas Administrative Code §134.402(f)(1)(A) states “The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent.”

CPT code 49507 is defined as “Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated.”

The MAR for CPT code 49507-LT is \$2,932.51(\$1,247.88 X 235%). The respondent paid \$1,451.28. The difference between the MAR and amount paid is \$1,481.23; this amount is recommended for additional reimbursement.

CPT code 49507-RT is subject to multiple procedure rule discounting. The MAR for CPT code 49507-RT is \$1,466.25 (\$2,932.51 X 50). The respondent paid \$725.65. The difference between the MAR and amount paid is \$740.60. The requestor is seeking \$704.64; this amount is recommended for additional reimbursement.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports additional reimbursement sought by the requestor. The Division concludes that the requestor supported its position that additional reimbursement is due. As a result, the amount ordered is \$2,185.87.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$2,185.87 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	6/21/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.